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FOR THE PHYSICIAN IN GENERAL PRACTICE

FALL, 1955

SUICIDE—Page 82

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The Cover

The scene of Samson's destruction of the temple of Gaza is depicted in the cover drawing by Joseph F. Schwarting. The betrayed, blinded, and enslaved Samson is probably the most well-known suicide of recorded history. According to the Biblical account, after Delilah caused the "seven locks of his head" to be shaved, he was captured by the Philistines who put out his eyes, bound, and imprisoned him. His captors neglected, however, to keep his head shaved and his strength returned. When he was summoned to entertain his tormentors in the great temple, Samson destroyed the building by crushing the two middle pillars with all his strength. He killed not only himself, but over 3000 died with him as he was avenged for the loss of his eyes. The desire for revenge is frequently the motive for suicide, although the reasons are not always apparent to the clinician or even to the victim himself. A discussion of the problem of suicide begins on page 82.

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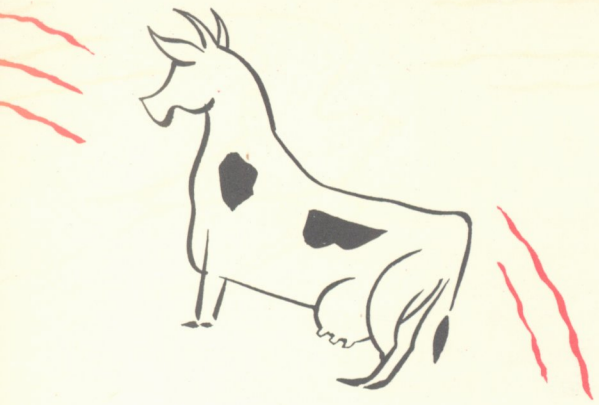
THE PSYCHIATRIC BULLETIN

Contents

johnny can

● IN HIS PRESCHOOL YEARS Johnny Adams was an exceptional child, a near-prodigy. Before he was five years old he could play the trombone (by ear), could count to 50, and knew his ABC's. He could memorize long poems merely by listening. In kindergarten Johnny was attentive and he enjoyed going to school. Then, Johnny went to the first grade where children are taught the fundamentals of reading. Unfortunately, at the end of his first school year, Johnny failed because he could not read. His parents were astonished and appalled. Obviously, the child was bright, and his auditory and visual tests were normal. Scolding and bribing were equally fruitless, and he became sullen and, progressively, more discouraged. Finally a discerning teacher discovered the cause of the reading disability. Although Johnny was especially retentive of almost any type of learning that could be acquired by ear, he was completely baffled when he tried to assimilate printed symbols. Further, he could not understand the difference in his early superior and effortless performance and his seeming inability to learn to read. When the functional and emotional difficulties were recognized, the boy was given a course in phonic remedial reading. Now, Johnny can read, but only because his difficulties were recognized early and corrected promptly.

It should not be assumed that only



the exceptionally slow children have reading disabilities. Children in all intelligence quotient ratings and in all social strata have difficulty in learning to read. Too often symptoms of reading retardation or dyslexia appear in the later grades and even in college. Indeed, some investigators have estimated that as high as 12 per cent of older school children have some degree of reading disability. Despite the high incidence, dyslexia does not receive from any branch of medicine the attention it deserves. In many instances the factors which interfere with the ability to read can be observed, prevented, and corrected with the help of the practicing physician. Reading disability may be the result of one or many abnormal factors. These include physical and emotional factors of varying degrees of severity, as well as the effects of poor teaching.

Physical factors in dyslexia

With the exclusion of organic brain lesions, there are four major physical bases for dyslexia. These are low intelligence, defective hearing, poor vision, and strephosymbolia. The physician can easily assess the intelligence of the child. Dyslexia should not be confused with alexia, or complete inability to learn to read because of lack of intelligence. Almost any pediatric textbook contains tables that enable the physician to determine roughly the child's intelligence rating. Actually, children with fairly low intelligence quotients can be taught to read. In most cases of dyslexia low intelligence is not the cause, since mental deficiency is usually recognized before a child is school age. Similarly, extensive loss of visual or auditory perception will ordinarily be evident before a child enters school. Nevertheless, in instances of profound reading disability, the ability to see and to hear should be ascertained as an integral part of the examination.

A final major physical cause of reading disability is believed by some authorities to be neurologic in origin. In 1926, Orton described his observations on strephosymbolia, a term that denotes twisted or confused symbols. According to Orton's theory, written symbols are confused by persons who are ambidextrous and have no dominant cortical hemisphere. About 75 per cent of the population is composed of right-handed persons whose left cortical hemisphere is dominant. About 12.5 per cent are left-handed (with right cortical dominance), and the remaining 12.5 per cent are ambidextrous and have no dominant cortical hemisphere. In persons with a normally dominant cerebral hemisphere, reading usually engenders no difficulty. In ambidextrous individuals with no stronger right or left cerebral control, written symbols have no obvious order or form. Words are perceived right to left; letters are reversed or misplaced; and even word meaning may be changed. Such persons are mirror writers or readers. Many strephosymbolics can write with equal ease with either hand, either forward or backward.

Many authorities disagree with Orton's explanation of lack of hand dominance as speculative and without definite proof. Although neurologic factors may not explain completely confusion of symbols, such symbol confusion does occur. In a recent survey, Swartout estimated that as high as 10 per cent of the school population may be affected to some degree by symbol confusion. He also describes a quick and simple test to determine whether strephosymbolia is the cause of reading disability. This test consists of having the patient write a column of numbers simultaneously with both hands. A right or left-handed person will write each column of figures as a mirror image of the other, whereas a strephosymbolic will make his numbers either exactly alike or inextricably confused. Before reading can be learned by these persons, a dominant eyedness and handedness must be fostered and developed.

Emotional factors in dyslexia

There is great divergence of opinion as to the importance of emotional factors in reading disability. Nevertheless, the majority of reading specialists and pediatric psychiatrists agree that reading disability is often an expression of emotional and social maladjustment. Although many problems are involved in reading disability, the most important factors are the child's emotional reactions, poor working habits, and lack of cooperation with others.

Obviously, the emotional and social deficiencies are not caused by reading disability. The child who enters school at the age of six is not unmolded clay, ready immediately to be impressed with the stamp of learning. Instead, the child brings his family problems and his personal problems with him.

The child's emotional reactions are those of discouragement and frustration when he finds he is less competent than his schoolmates. He may have been subjected to a sequence of discouraging experiences

with his parents, and inability to learn to read may discourage him even further. Parents may overprotect children at one time and then demand too much at another. The result is that the child loses confidence in his own ability.

Often, children with reading disabilities are overambitious and cease trying when immediate excellence seems impossible. With consistent failure, a child may ultimately come to believe that he will never learn to read. His discouragement may lead to open defiance or to passive rebellion, in which he flaunts his disability. By a display of indifference he tries to avoid an anticipated renewal of failure.

Poor working habits frequently contribute to a child's difficulty in learning to read. Many children at the time that they enter school have had no previous responsibilities. Such children resent occasional chores at home, and this resentment may be transferred to all types of work. These children are restless, have a short span of interest, and avoid all activities except those of amusement or novelty. To expect nothing useful of a child for six years and then to subject him to the pressure of classroom discipline and learning is actually to require more of schooling than should be expected.

A lack of willingness to cooperate with others may impede ability to learn. The manner in which a child adjusts to his classmates and teachers is affected by the attitudes and habits he has acquired at home. In some cases, reading disability is an expression of antagonism toward parents and of reluctance to cooperate or to accept direction. Children not trained to observe order will refuse to accept rules or to conform to them. When a child is unwilling or unable to follow directions there is usually some degree of disturbance in his interpersonal relationships. In most cases, coercion only aggravates the emotional disturbance and the resultant social maladjustment. To the child, enforced cooperation only signifies submission to authority. Forcing him to repeat an assignment until he learns it is thus often defeating. Instead of demanding cooperation, it is better to stimulate motivation. Until a cooperative attitude has been engendered, not forced, the child cannot resolve his deficiencies.

Poor teaching factors in dyslexia

Many parents blame the teacher for their child's inability to read, which results in an additional conflict of which the child may be aware. Also, there is much current controversy as to the merits of the so-called "progressive" method of learning to read as compared with the "old-fashioned" ones. In the earlier method, the alphabet was learned first, then word endings by groups, then the adding of words to make sentences. In the newer method, the child is first familiarized with whole words, so that actual letter recognition comes later and automatically. There is, therefore, less emphasis on the mechanics of words and more emphasis on their meanings. This system appears haphazard and unproductive to many parents. Actually, in most cases, the latter method is superior in resultant reading speed and comprehension. For some children, like Johnny Adams, who are predominantly "ear minded," extra phonetic teaching is necessary. If parents feel that teaching methods are unsatisfactory, there are many ways in which teaching can be augmented by home training.

Home training does not include teaching the child to read. Most teachers prefer that children not be taught before they enter school. Instead, training with words can be really helpful. Since the child learns first by listening and talking, practice in communication will widen his vocabulary. Another form of talking is, of course, story-telling. Whether the parent makes up stories or reads aloud to the child he enhances the importance of reading and makes the association one of pleasure. Small children enjoy repetition, and word repetition makes them word-conscious. The child's accrued experience is also important and serves to make the things he reads about more meaningful. The parent who listens and answers with real interest all of the small child's questions will add much to that child's vocabulary. If all the questions about the corner grocery, the zoo, the firemen, and the policeman are answered, many fascinating new words will be learned. Everything, from the label on a can of tomatoes to the directions on a fire extinguisher, can have significance for an inquiring child. By the time he goes to school the child who is home-trained may be able to recognize several common words or at least the association of a word with its object. Talking, reading, and providing the child with new experiences are all forms of teaching that afford a background of knowledge to aid memory. Such memory aids will help to prevent reading disability.

Each child with a reading disability is a separate problem, although in most instances the difficulty may be regarded as a symptom of emotional disability. The neurotic conflicts are non-specific and numerous. Reading retardation is not a permanent and inevitable consequence, nor is it an emotional disorder sufficiently serious to warrant psychotherapy in the majority of cases. Obviously, the physician does not have time to undertake remedial reading instruction. He should, however, be cognizant of special facilities now available in many communities. Most reading specialists are in local colleges or in the public schools. If the community has no reading specialists, the physician can contact the local school officials and the reading consultant in the state department of education in an effort to add a specialist to the local school staff.

In cases of dyslexia, the possibility of physical disability should first be excluded. In addition, underlying emotional disorders should be recognized. In most cases, encouragement will increase the child's belief in himself. Such encouragement not only helps his reading, but also exerts a helpful influence on his total personality development. In particular instances, as with Johnny, a specific reading disability can be overcome by sympathetic tutoring. With comparable help and encouragement, all the Johnny Adamses can read.

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Saint Elizabeth's

CENTENNIAL

THE PHRASE "a century of progress" can be appropriately used with regard to the distinguished record of St. Elizabeth's Hospital in Washington, D. C., in this its centennial year. When the institution was opened in 1855 it was for the express purposes of " . . .humane care and enlightened curative treatment of the insane of the Army and Navy and of the District of Columbia," according to the bill signed by President Franklin Pierce.

From the beginning, St. Elizabeth's program was characterized by the progressiveness and humanitarianism that are associated with the work of Dorothea Lynde Dix. The history of the hospital is inextricably bound with that of the tireless tuberculous school teacher who began in 1841 a reform program at which she worked for 40 years. Dorothea Dix was personally aware of the need for improved care for indigent psychiatric patients, and her efforts were for a long time directed toward the establishment of this particular institution. In fact, she drafted the original act that was presented to Congress. In her lifetime she aided in the founding or enlargement of more than 30 state hospitals in this country and continued her program for institutional reforms in Europe as well.

Originally, St. Elizabeth's was formally named The Government Hospital for the Insane. The land appropriated for it was called after the patron saint of lepers and insane persons, St. Elizabeth of Hungary. The name of the institution was officially changed by Congress in 1916. This was the sixteenth of the institutions for whose founding Dorothea Dix had worked, and by 1862 it was the largest in the United States.

One aspect of the hospital that was unusual for the time was the value placed on attractive surroundings for mentally sick patients. The need for personal comfort and some form of occupation was recognized, as was the importance of trained and tactful personnel.

The hundred years have been progressive, eventful, fruitful ones. The hospital has had five superintendents, and each has been president of the American Psychiatric Association. St. Elizabeth's has many "firsts" to its credit. It was at this hospital that military psychiatry was first introduced in this country, soon after the Russo-Japanese War. The hospital was among the first to establish departments of neuropathology and clinical psychology, as well as a school of nursing. Hydrotherapy was introduced at this institution as early as 1897. For the first time in an American hospital psychoanalytic techniques were used in the treatment of schizophrenic patients, and the malarial treatment for paresis was given for the first time in this country. This was the first public mental hospital to use psychodrama as a therapeutic method. Even today, St. Elizabeth's is the only public institution for mental patients to offer an internship approved by the American Medical Association.

St. Elizabeth's has an extraordinary record and has never been exclusively identified with any particular school of psychiatric theory. It is now a unit of the United States Department of Health, Education, and Welfare. Its annals demonstrate the humanity and enlightenment advocated by Dorothea Lynde Dix.

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Emotional Problems of the

● THE BREAST is the most common site of malignant neoplasm among women in the United States. About one out of every four women with cancer has breast cancer. It is estimated that approximately one out of every 1,480 women in the United States develops cancer of the breast each year. Therefore, it is imperative that the physician be cognizant of the psychological aspects of the disease.

Fear and anxiety

The most apparent emotional factors in cancer of the breast are fear and anxiety. The fear is usually, at least in part, a conscious phenomenon. However, labeling the effect "fear" does not clarify understanding or treatment of the patient. What is it that the patient fears? As with most psychological problems, there are usually many causes of fear. In most cases the consciously perceived fear is related to several common causes. Often, too, the most important fear-producer is denied and the fear is related to a cause which can be verbalized.

Fears which are verbalized as "fears of cancer" are seldom specific. The patient who is unable to formulate her response in direct terms may develop debilitating anxiety. The real relationship between the cause and the response-symptoms of nervousness, tension, and inefficiency remains hidden, and a generalized, free-floating anxiety is likely to develop. Fear, like cancer, is not self-limiting. In the treatment of cancer patients effort is made to control the disease at its primary site before it has spread to other anatomic structures. Similarly, anxiety should be controlled at its original area of involvement before other personality functions are affected.

Since cancer and imminent death have for years been equated in the American culture it seems safe to assume that the fear of death is present in some degree in all cancer patients. This fear is not pathological unless it causes the patient to neglect the bounds of reality, or unless it is repressed and unrecognized and thereby causes a perpetuating and uncontrolled anxiety state. In the first instance the patient may be unable to accept any realistic hope which the physician gives her. The fact that 75 per cent of early cancers of the breast can now be cured may be interpreted by the patient as "helpful lying" on her physician's part; or she may insist that she is part of the 25 per cent that will not be cured. Since a certain amount of skepticism is normal, the physician must be ready to evaluate the degree of disbelief shown. Complete denial of fear of impending death is unusual among well-adjusted patients.

A common fear which mothers of young children frequently experience is closely associated with the fear of death. They contemplate the future of their orphaned children growing up without maternal love and care. These patients fear for others, not themselves. Although this socially laudable fear may be a projection of fear for self, in many cases it is a real concern. Always, unless there are indications to the contrary, an expressed fear of this sort should be taken at face value. If it is true that arrangements have to be made because of the imminent demise of the patient, the physician may have to assist her and her husband to make appropriate plans. Also, this fear may be unnecessary if there is no real danger of impending death. In these cases, the principal focus of psychotherapeutic efforts would be to bring the patient's fear of death into the bounds of reality.

Case history of fear of cancer

A 41-year-old mother with breast cancer reported having recurrent nightmares during the course of preoperative irradiation. She had slept poorly and had begun to have nightmares since the time she was informed of the probable diagnosis. In recurrent dreams the patient was attacked by black snakes. She awakened from the nightmares screaming, dyspneic, and sweating. During the first dream one large, black, slithering snake attacked her. Soon after, the patient was told the disease had spread beyond the original focal point in her left breast. After this the nightmares included many black snakes surrounding and crawling over her. The patient associated the snakes with the tumor growth, as symbols of the cancer that was attacking her. At the beginning of psychotherapy, the only fear which she could verbalize was the fear of cancer. She said, "I'm not afraid of dying, though people say I am, but nobody likes to be attacked." In a few sessions, however, she talked about other fears. These included her own fear of dying, her fear that her five-year-old daughter would grow up motherless, and her concern and distaste for her husband's sexual aggressiveness, which displeasure antedated her illness. Extensive psychotherapy was not attempted, nor indicated. In a few sessions, the patient was allowed to ventilate her feelings and after this the nightmares ceased. Psychotherapy was completed by several sessions spent in planning her immediate and distant future. These plans concerned the treatment she was to receive, alternatives for the care of the child should she become too ill, and contrasting her previous and present attitudes toward her problems. The nightmares did not recur during the 18 months of follow-up study. Such therapy can and should be attempted by the patient's physician when disturbing symptoms are present.

This patient had another prominent fear. It concerned her family's financial condition. Since she was being treated in a publicly supported hospital her problem was easily solved by an adjustment of fees. In general hospitals, however, the problem of paying for extensive treatment requires both careful and humanitarian management by the

Breast Cancer Patient

physician. Planning of a schedule of payments from the estimated cost early in the treatment will do much to alleviate unnecessary worries at a time when the patient's entire energies should be utilized in the attempt to recover.

Fear of surgical mutilation

The patient's fear of surgery and her response to the surgical amputation have especial meaning with breast cancer patients. Although the breasts are symbols of adequacy of the woman's sexual role, the importance of this symbolism has been exaggerated in American culture. Furthermore, in more than three of every five, erotic significance of the breast has been associated with sexual response. Also, the breasts are important symbols of adequacy in the role of motherhood. Any damage to the body image, the threat of loss, or especially the actual amputation of the breasts, can be profoundly disturbing to many women.

A therapeutic program should include evaluation of the ego strength, assessment of the degree of personal investment in breast symbolism, communications of the physician's recognition of the problem, explanation of the basic symbolism involved, psychological support by suggestion, and finally, an explanation that mastectomy does not destroy physiological function.

Case history of over-investment in symbolism

A 47-year-old married, postmenopausal woman had a right mastectomy. Postoperative course was uneventful and the wound was completely healed within four months. There was only slight edema of the upper arm and arm movement was considered good six months after surgery. At that time she complained of periods of excessive nervousness. Phenobarbital, grains ½ to be used three times daily, was prescribed. However, two months later the patient's nervousness was worse and she complained of periods of dysphoric moodiness. Personality evaluation showed that she was above average intellectually, fairly adequate in most spheres of behavior, able to withstand most stresses, and was not mentally ill. Three months later, she reported that periods of depression occurred at the end of each month. The depression was increasing in severity, and she complained of progressive loss of sexual drive and increasing sexual frigidity. This symptom had its gradual beginning soon after mastectomy. Then, there was a discussion of the meaning of her figure and breasts. She revealed that she was unable to look at the mastectomy scar for more than four months after surgery, although she had been a close observer of her scar from an appendectomy six years before. An explanation was made to the patient concerning the breasts as symbols of femininity and of sexual capacity. A comparison was made between the symbolic meaning of the breasts and the symbolic meaning of her wedding ring. As symbols, both were important to the patient. If she were to lose her wedding ring it would not mean that her marriage had become nothing. Her marriage would remain real, stable, and vital. Similarly, loss of the principal symbol of femininity and sexual capacity, the breasts, did not affect her real adequacy as a woman. Other aspects of living in which she had been successful were emphasized, such as her activities as a church and civic worker, as a cook with a neighborhood reputation, and as a mother. During the discussion the physiological and anatomical importance of the breasts were discussed, and the conclusion was reached that, although the patient did not like breast amputation, her adequacy as a woman was not destroyed. The entire psychotherapy consisted of five interviews. During first discussion of breast symbolism, the therapist had suggested that symptoms of sexual frigidity would gradually disappear. This occurred, and the night after the third session the patient experienced orgasm for the first time in many months. Follow-up studies have continued for two years and there has been no recurrence of psychological symptoms.

Indications for psychotherapy

When a patient shows signs of disorganization and emotional lability *immediately* after being informed of the diagnosis of cancer of the breast, supportive psychotherapy is usually sufficient. The patient should be given time to incorporate the idea into her personality functioning. Obviously, it takes time for an individual's own adjustive defense mechanisms to afford reorganization during such a stress as the diagnosis of cancer. If further difficulties arise through failure of the defenses of the patient, some form of psychotherapy may be instituted.

Within the past few years several research papers have been published concerning the personalities of women with cancer of the breast. In general, in this work cancer of the breast is regarded as a psychosomatic entity. A review and appraisal of the work in this new field of cancer research will be presented in a forthcoming issue of *The Psychiatric Bulletin.*

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PREVENTIVE PSYCHIATRY

● VIRTUALLY every professional contact with a patient offers the physician an opportunity to practice some preventive psychiatry. Fear and anxiety are either major or minor components in every sick, injured, troubled, or unhappy person seeking medical help. Paradoxically, the more effective and timely the physician's handling of these factors the less will the patient appreciate the full significance of his efforts. No one *expects* to develop a mental or emotional illness; similarly, no one *expects* an auto collision when travelling. Just as a good driver knows how to anticipate a potentially dangerous situation on the highway, the physician can become skilled in anticipating possible crises in the emotional lives of his patients.

The author of a book on child care once wrote that many mothers had asked her to put out an indexed volume, so that they could look up "thumbsucking," "bedwetting," and so forth, and get a quick answer for handling the problem. Unfortunately, no such cookbook methods can be applied to human behavior. This is obvious when one considers the many variable factors that must be weighed.

There are three general factors which must be evaluated: These are (1) the individual's hereditary and constitutional endowment; (2) his *learned* patterns of behavior, particularly those relating to interaction with other human beings; and (3) the environmental circumstances with which he must deal.

Heredity and Constitution: Obviously, certain hereditary factors must be accepted. The physician must recognize the individual differences. Nevertheless, an undue emphasis on heredity should not be used to justify inaction or lack of interest in emotional problems. The physician recognizes certain needs, common to all mankind, which must be met to insure growth and ultimate maturity. This applies as much to emotional needs as to nutritional and other physiological needs. Even with these inherent needs, however, there are individual differences in intensity.

Learned Patterns: The child soon learns that some actions bring approval, others disapproval. His need for affection and security is so great he will even renounce some normal needs to gain the parents' favor. If his learned behavior patterns deviate too far from those generally acceptable in his environment, or if they significantly negate the satisfaction of basic needs, maladaptation, neurosis, or psychosis will result.

Consequently, it is obvious that preventive psychiatry should begin in the care and training of infants and children. A great obstacle is the "one generation lag." By the time individuals become parents their own emotional patterns are well established and only slightly modifiable by simple educational means.

Environmental Influences: The significant environment for the small child is the immediate family. As he grows, the neighborhood, the school, the play group, clique, or gang, and ultimately the whole community become important. The importance of environment on mental health has implications which have drawn the interests of physicians into fields far outside the traditional domain of medicine.

Just as the drainage of swamps may be vital to a malaria control campaign, the mental health of a community's citizens is affected by such things as job security, housing conditions, social class pressures, and recreational facilities. The family physician should familiarize himself with the resources of his own community; he will frequently be asked for professional counsel regarding the expansion and improvement of those resources. In this area the professional skills and interests of medicine overlap with those of the social sciences.

Critical Phases in the Life Cycle. Skillful application of the principles of preventive psychiatry is also aided by the knowledge that there are definite crucial periods in the life history of all individuals. Each has its emotional problems. These are: (1) infancy and early childhood; (2) adolescence; (3) marriage and parenthood; (4) the climacteric; and (5) old age.

Infancy and Early Childhood: If a physician were to discover that a child under his care was being half-starved by a food-faddist mother, he would rightfully attempt to correct the situation even if it meant challenging some of the mother's most cherished ideas. Similarly, the physician must sometimes deal with an emotionally pathogenic parent. The parent may not be clinically ill but by being over-protective, rejecting, dominating, or excessively rigid thwarts the emotional growth of the child. Like Typhoid Mary, the parent may be a "carrier" of pathogenic influences.

Admittedly, in many such cases therapeutic efforts are limited. For example, it is better to do nothing than to precipitate hostility and anger by directly challenging the parents' management of a child or by implying any lack of affection. Where one or both parents are receptive to counseling, a great deal may be accomplished. Intelligent parents may be helped by reading books on child care such as those by Dorothy Baruch and by Hilde Bruch. Other corrective measures may be indicated, such as placement of the child in a day school or nursery, or even foster home placement; the physician should acquaint himself with the medicolegal means applicable to such extreme problems.

Adolescence: There is a unique opportunity for the family physician to mitigate the stress of adolescence for his patients. If a warm, sympathetic relationship has already been developed, it will be relatively easy to find an opportunity to discuss the adolescent's emerging sexual feelings, to supply factual information, and to serve as a sympathetic listener to the teen-ager's ambivalent feelings toward his parents. It is inadvisable to show partisanship in parent-adolescent issues; the rebellious, resentful feelings should be accepted calmly and uncritically.

The physician will sometimes be tempted to take a parental role himself, but this should be minimized except in cases in which the real parents are so inadequate that a substitute parent is more desperately needed than an unbiased adviser.

Marriage and Parenthood: This is the period of assumption of adult responsibilities, and implies a renouncement of childhood dependency. It would undoubtedly be better if everyone could break the childhood ties to parents before marriage and parenthood, but this is often not possible. Premarital discussions about living arrangements, management of in-laws, and division of responsibilities can often be more helpful and illuminating than talks pertaining to sexual adjustment.

Emotional preparation for parenthood should be part of every prenatal program, particularly with the first child. Here again it is better that both parents participate in planning for parenthood. Many young mothers are surprised and disappointed because they expect to be enveloped in maternal tenderness at the first sight of the baby, and the sublime emotions of motherhood often do not materialize. If maternity is over-idealized, some are unprepared for the normal irritation and resentful feelings that normally occur in the first months of infant care. In some instances this may result in repression of the resentment, and by the process of reaction formation, the development of over-protectiveness and inordinate fear for the baby's well-being. In discussions during the prenatal period, the physician can detect and often alter such unhealthy, unrealistic attitudes and expectations. Such discussions often pave the way for future dealing with emotional problems in relation to the child.

Climacteric: In women, the menopausal years usually require considerable emotional readjustment. This should be anticipated and discussed well ahead of time. The development of interests and activities to supply the need for a sense of usefulness is perhaps the most important. This is especially true for women who have previously devoted themselves largely to rearing children.

Although any physiological equivalent of the climacteric occurs much later in men, there is a similar phase of emotional readjustment in the fifth and sixth decades. This relates to the realization that physical powers are on the downgrade, the future is no longer a limitless horizon, and that youthful ambitions are not all capable of fulfillment.

Old Age: Preparation for retirement is becoming a more important subject each year. Many men vaguely expect just to take it easy, or fish all the time, or putter in the yard, and in six months after starting retirement are at their wits' end. For many, it is feeling useless that puts the greatest strain on their equilibrium. A planned, definitely scheduled activity can make all the difference. Arbitrarily, one might advise a schedule requiring around one-half to two-thirds the hours per week formerly spent at work.

Other problems of aging, such as fear of invalidism and dependency, loss of spouse, and fear of death all have their special emotional aspects. Generalizations as to management are not of as much value as an awareness that the problems exist and a thoughtful approach by the physician to the needs of each individual patient.

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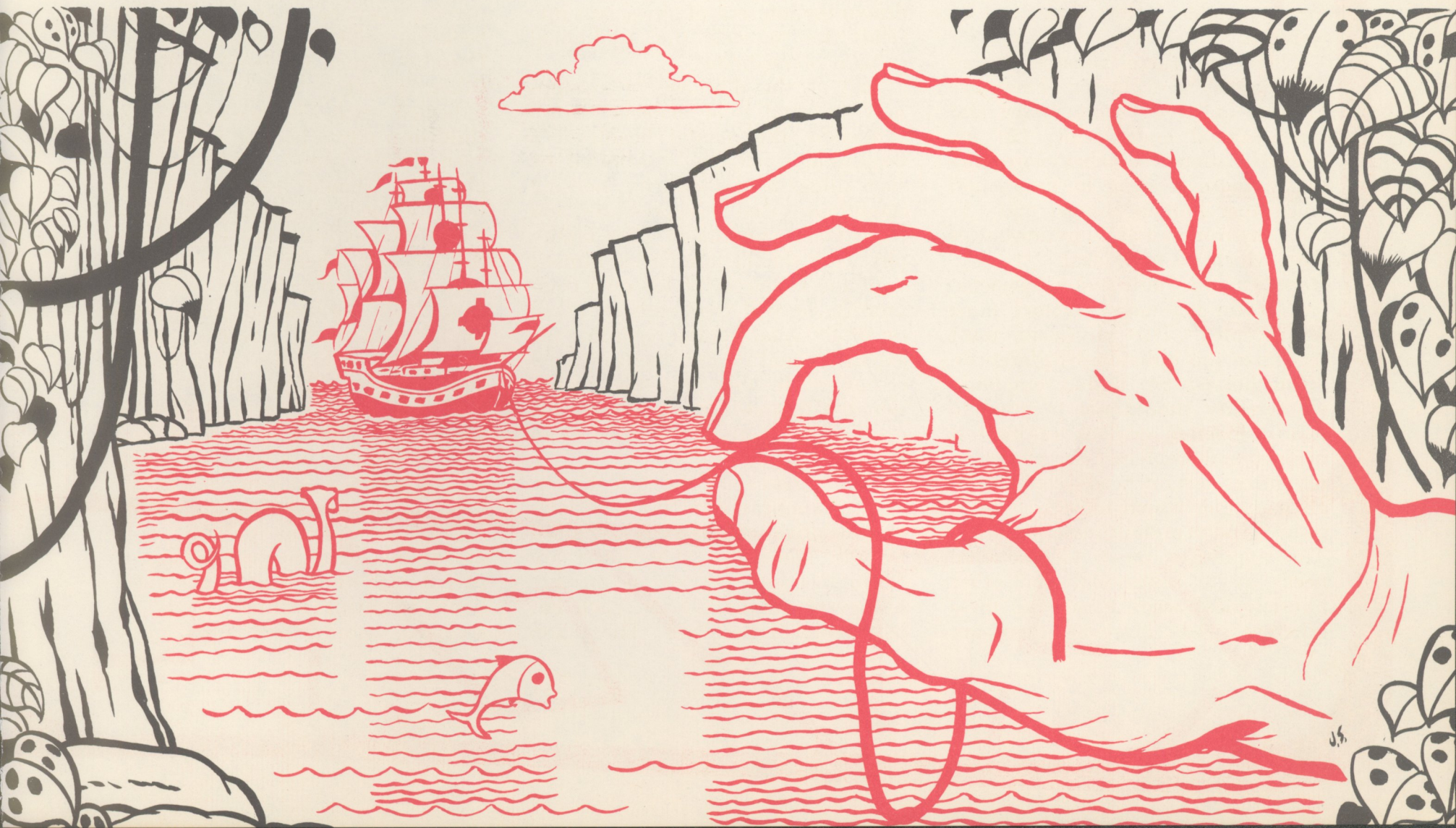

SUI

● IN THIS COUNTRY, about 16,000 suicides are recorded each year, almost ten times the annual mortality from poliomyelitis. Suicide ranks ninth in causes of death, and an additional 100,000 attempts at self-destruction are made each year. Since there are about five unsuccessful attempts to every self-inflicted death, many physicians will, at one time or another, have an opportunity to detect a suicidal risk.

Ethnological concepts in suicide

Suicide is a major human affliction and has constituted one aspect of behavior throughout the history of mankind. Suicides have included such widely different personalities as the Biblical figures of Samson and Judas Iscariot and the scientist, Semmelweis.

A historical approach to the subject shows that the psychodynamics of suicide have been obscured by moral and legal traditions and by conflicting medical opinions. To most laymen and to many physicians, suicide is still regarded as a result of mental aberration, an act usually performed during a state of severe depression. This explanation, although expressed in different terms, is much the same as that of the early Christian scholastics.

The Greco-Roman idea that suicide was not incompatible with morality was supplanted by church dogma that suicide was a heinous sin, a repudiation of the commandment not to kill. Successive councils of the early church confirmed this concept, since sin was regarded as any voluntary surrender of the reason to the forces of evil. During the Middle Ages, this church ruling reduced the number of suicides by denial of church burial. Since this ruling was part of church law, suicide became both a sin and a crime. During the Renaissance, with its revival of Greco-Roman ideas of life and death, suicide lost some of its connotation of sinfulness but few of its criminal aspects.

In Great Britain, until 1823 suicides were still buried at crossroads, with a stake driven through each body. This procedure was abolished by law, and in 1870 forfeiture of lands of suicides was also discontinued. Under present British law, however, suicide is still a crime—*felo de se*—and attempted suicide is punishable by imprisonment. This constitutes a medicolegal paradox, since the verdict of sanity or insanity often depends upon the success of the suicide attempt. If the victim kills himself he is usually declared insane and absolved from blame; but if he fails he is pronounced sane and is liable to prosecution. In Canada, attempted suicide is punishable by two years' imprisonment, and in at least four states in this country a suicidal attempt is considered a criminal act. Thus, the stigma of sin and crime is still

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attached to suicide in major English-speaking countries. Besides the Judeo-Christian and Mohammedan cultures, few ethnologic groups have emphasized the moral aspects of self-killing.

There has been an obvious tendency in popular and even in medical opinion to express the traditional disapproval of suicide by limiting suicidal reactions to persons who are "insane" or "temporarily of unsound mind." Zilboorg regards this attitude as the major reason why there has been no constant systematic search for a special pathologic basis of suicide.

Theories of causation of suicide

Although patients with depressive psychoses more often attempt suicide than any other group of mentally ill patients, many persons who are not depressives do commit suicide. Indeed, Schmidt, Schneider, and others estimate that only 10 to 20 per cent of all suicides are insane. Similarly, it is oversimplification to assume that suicide is a consequence, necessarily, of ill health, financial troubles, despondency, or unrequited love. Although suicide is construed as a result of severe aggressive impulses that are turned inward, this theory is too general to explain the psychodynamics of suicide. Almost as many motivational factors have been mentioned as there have been individual cases. Among the most commonly cited reasons are self-punishment by which the person hopes to obtain atonement and forgiveness, revenge and a desire to get attention, loss of a loved object, desire to be "born again" blamelessly, religious aspiration for Heaven, and escape from intolerable situations.

Although any of these elements may be involved, the underlying motivation is much more complex, and, in most cases, can be traced to the early life of the individual. Suicide is generally the result of a conditioned personality that meets suddenly with a reactive external stress. The motivation of self-destruction might be considered analogous to a form of anaphylactic shock. The patient is hypersensitized to a particular stress, and if this stress is suddenly injected into his enviornment it sets off a fatal reaction. Obviously, if this explanation is correct, to find the antigen or causative factor that impels an individual to take his own life would necessitate months of psychoanalytic study.

Most of the case histories of suicides that were committed during psychiatric treatment have included evidence of severe rejection by one or both parents with resultant dependence and hostility. Such rejected individuals are able to maintain a state of precarious balance as long as there is some semblance of acceptance. When such a person experiences a specified overt rejection,

either real or imagined, that strongly resembles an earlier traumatic one, he is no longer able to repress his conflicts. Then, the hostility may become conscious and inverted. The specific rejection usually occurs at a time when the patient is already constrained by hatred and strong guilt feelings resulting from the conviction that he is unworthy. By the act of self-destruction he seeks atonement for his guilt. The situation which involves outright rejection may be comparatively trivial, such as loss of a job, or profound, such as loss of prestige or honor.

Suicidal thoughts are universal in that they occur to mentally sound as well as to mentally unsound persons. Among common experiences are fleeting impulses to leap from a high building or into the path of an oncoming train. These are, however, usually no more than momentary fascinations with extreme danger, and they seldom result in self-destruction. In cases of actual mental disease, suicidal impulses exist in some degree in almost every form of disorder. An important factor in suicide is its motivation as an escape from overwhelming anxiety. This is often the reason for suicides in patients just developing schizophrenic reactions. Suicidal tendencies are, of course, greatest in depressive states, whether in early life, middle life, or during the involutional years. It is no longer believed that manic depressive psychosis is the primary cause of suicide.

In a recent report by Schmidt and others, 109 patients who attempted suicide were intensively studied eight months after the episodes. Two thirds of all patients were classified in one of five diagnostic categories. These were manic-depressive depression, including involutional melancholia, 16 per cent; psychopathic personality, 15 per cent; chronic alcoholism, 13 per cent; hysteria, 12 per cent; and dementia (vascular disease or senile psychosis), 11 per cent. There were no patients with anxiety neurosis and none with psychoneurotic depression. This latter finding is contradictory to the belief that psychoneurotic patients are the most frequent suicides. The only diagnosis of neurosis was that of hysteria, and this study shows that depressed feelings during hysteria can be severe enough to prompt a patient to a serious suicidal attempt.

In this long-term study patients were classified into two groups, one who made serious suicidal attempts, and the group who made only suicidal gestures. In the not-serious group, 51 per cent of patients were drinking at the time of the attempt as contrasted to only 14 per cent in the serious group. Patients who were drinking just before the attempt comprised 39 per cent of the total. Excluding patients with manic depressive depression and dementia, the average age of patients in the serious and non-serious groups was essentially the same. The authors interpreted this fact as evidence that older persons make more serious attempts than younger ones. Possibly this results from the more frequent occurrence of manic depression and dementias in older patients. There were ten different diagnostic categories in the entire group of 109 patients.

Detecting the suicidal risk

In many instances it is impossible to detect a patient's suicidal tendencies. Nevertheless, there are certain signs that may be recognized as indications of potential suicide. These include morbid preoccupation with ideas of self-depreciation and guilt, painful fears, feelings of helplessness, uselessness, or of being a burden to others, and fear of being disliked or harmed by known or unknown agencies. Any one of these attitudes may be the only overt indication of suicidal impulses. Furthermore, a patient whose personal life either present or future appears to afford no pleasant feature, who feels hopeless of being happy or active, or who suffers from sheer boredom may attempt self-destruction. Frequently, any of these emotional aspects may be present without other signs of emotional disturbance.

Fortunately, there are definite diagnostic signs of depression. Some of the early diagnostic signs and symptoms are persistent insomnia, anorexia, loss of sexual drive, and cessation or diminution of menstruation. Many patients who are depressed will not admit to despondency. In such cases, only careful questioning may elicit that the patient actually is discouraged, worried about his marriage or health, or feels harrassed because he cannot sleep.

Many depressed patients will readily admit suicidal fears. Although it is commonly believed that persons who talk about suicide are unlikely to attempt it, this is not true. Most threats of suicide are the result of genuine suicidal impulses and may result in a serious or successful attempt. Hence, no threat of suicide should be disregarded as insignificant. Furthermore, the likelihood of suicide is greater in persons who have made previous attempts.

The possibility of prevention of suicide depends upon recognition of such warning signs as mood changes, expressed intentions, and despondent attitudes. Some suicides are not preventable because the patient may give no advance suggestion of intent by appearance, expression, or behavior. Treatment of the depressed patient is a definite measure of prevention. Similarly, treatment of patients who attempt suicide is a prophylactic measure. To achieve reduction in suicides, social prejudice must be counteracted so that family and friends will obtain adequate care for such patients. Similarly, after an attempt the physician must do more than perform gastric lavage or surgical repairs. If such patients are given psychiatric care and the underlying disturbance is recognized and alleviated, many suicides can be prevented. After any suicide attempt, the patient should be hospitalized and observed under 24-hour supervision until a careful evaluation can be made. Suicide should not be considered as an isolated phenomenon but as part of the total personality with all its component strivings and conflicts. These individuals are neither brave nor cowardly, but are disturbed persons who need immediate and expert help.

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Chronic Fatigue

● THE TERM "fatigue" connotes both muscular depletion and the subjective feeling or awareness of tiredness. The two conditions are wholly different. Although in normal persons ordinary work causes both muscular tiredness and subjective fatigue, the fatigue disappears with adequate rest. In contrast, fatigue that is not dissipated by rest is designated chronic fatigue or pathological fatigue and requires measures other than rest or cessation of work to remove it. When fatigue is disproportionate to the actual exertion, there is usually some element of emotional involvement.

Emotional fatigue

Neurological diseases, such as myasthenia gravis, will cause muscular impairment and resultant fatigue. This sort of fatigue is not found in normal healthy persons. Much of their weariness is caused by situational problems associated with daily living. The origin of this fatigue is mental or emotional; therefore, physical rest is not the logical or correct treatment. In many patients, fatigue develops from anxiety, fear, sorrow, depression, or monotony. Fatigue is related inversely to interest and ambition. For example, when personal interest in an activity is high there is a greater performance potential and fatigue occurs less regularly. Hence, when motivation or incentive is increased, fatigue is impeded. Actually, when fatigue is a manifestation of boredom, a change of scene or a new interest may dissipate the fatigue and may be the only therapy necessary. For instance, after a day of semiphysical exertion, recreation such as bowling may be undertaken. Because of new motivation, the fatigue not only recedes but the activity is revivifying even though it requires further effort.

Psychodynamic considerations

Fatigue that results from exercising at a high rate, from a febrile illness, and from conflictive activity at a psychological level are dissimilar even though the accompanying aches and pains may be much alike. At the psychological level, the fatigue may serve a complex defensive purpose. The patient unconsciously feels tired in an attempt to subserve various hidden psychologic needs. The fatigue may act as a danger signal of some activity or attitude that has been persisted in too long or too intensely. Furthermore, fatigue protects the individual's concept of himself since it is a socially acceptable disorder. Hence, the patient can retain his self-esteem with a symptom which at least implies an origin in hard labor or overwork. Society approves the hard worker and such implications secure the patient sympathy and regard that may be even ego-building. The fatigue also may serve to deny, conceal, or control rejected wishes or needs possibly unrecognized by the patient. Besides, less may be expected or demanded of the person who is chronically fatigued. This dependent appeal may be related to an effort to delay action or to avoid a decision or responsibility.

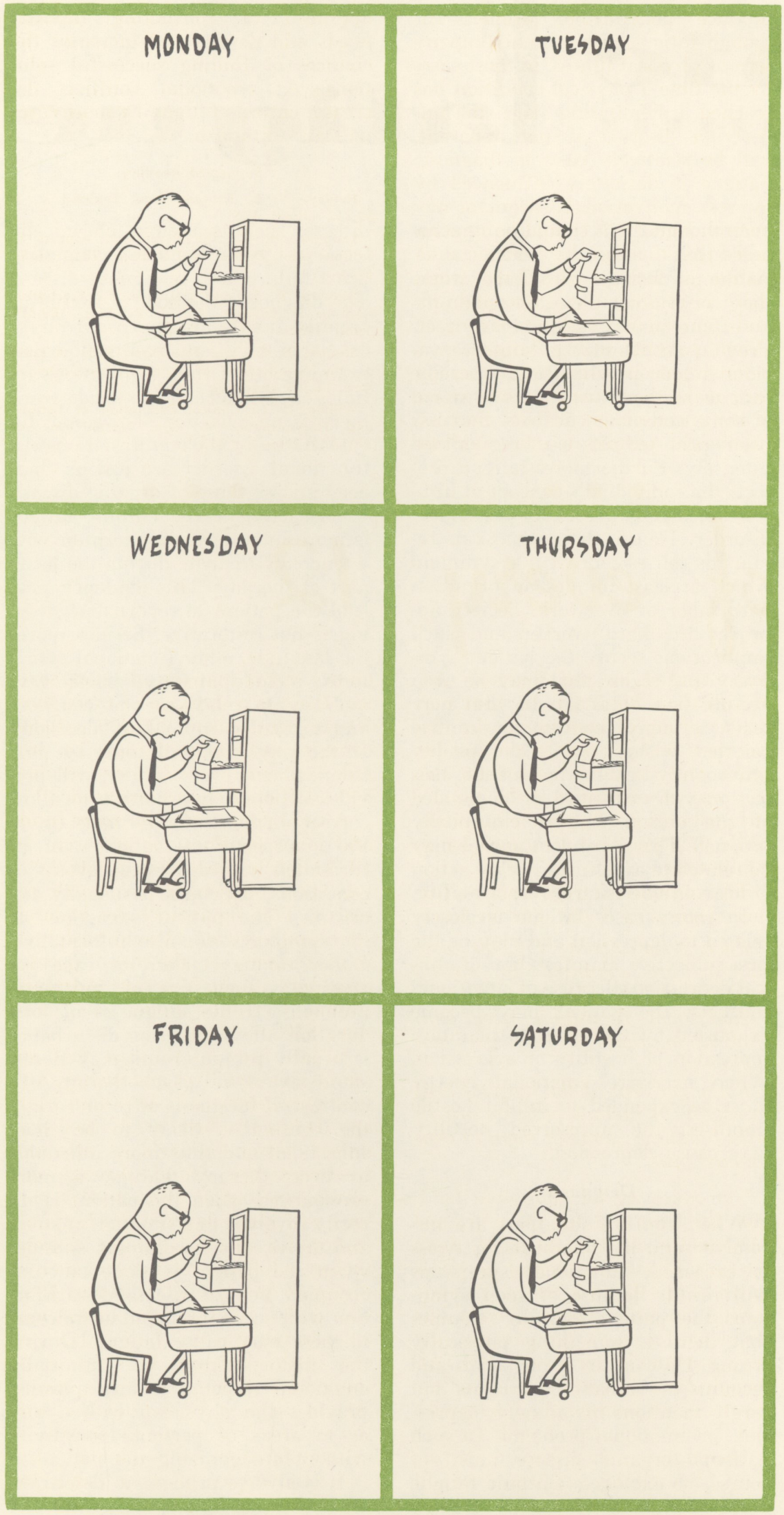
In many cases fatigue is closely related to depression and may be the first subjective manifestation of clinical depression. Because of situational conflicts, the patient may become exhausted by the effort to maintain repression of hostility or aggression. When excessive emotional energy must be expended to inhibit hostile impulses, the unresolved hostility may cause depression.

Diagnosis

When conflict situations are unresolved and the tolerance for stress is exceeded, functional symptoms will result. Because of such symptoms the patient logically assumes that there is something physically wrong. He consults a physician and recounts his somatic complaints, but rarely mentions his anxiety, depression, or emotional problems. In such patients, organic disease must, of course, be excluded. Chronic fatigue occurs commonly in many organic diseases such as anemia, chronic infection, hypothyroidism, congestive heart failure, and malignant disease. The diagnostic methods of excluding organic disease are the usual physical, laboratory, and roentgenological examination. Often a diagnosis of functional disturbance is made when there is no evidence of organic disease. Actually, the manifestations of a functional disorder are just as characteristic as those of organic disease.

Characteristically, chronic fatigue is more intense in the morning with a tendency to abate during the latter part of the day. This tendency may lead the patient to report that sleeping is not restorative. Besides morning lassitude, other functional symptoms include anxiety, irritability, inability to relax, mental conflicts, and difficulty in making decisions. If the physician will only sit and listen, almost every patient will provide sufficient information to allow correct diagnosis to be made or, at least, suspected. If fatigue can be correlated with distressing events or conditions, the cause is usually not organic. The patient's reactions to his symptoms are also informative. Either undue concern or excessive apathy is suggestive of functional problems. If the fatigue is of long duration, the underlying disturbance is usually profound and may necessitate extensive psychotherapy. In contrast, if fatigue is of recent origin the conflict is likely to be more superficial and thus more amenable to direct therapy. Fatigue is more pronounced when the patient is directly involved in a situation of stress and the tiredness seemingly subsides when the patient is alone and unoccupied. Fear of disease, dissatisfaction with occupation, and unwelcome idleness may cause fatigue. During the history-taking, an unusually emotional response to any question provides the physician with a hint as to areas of personal sensitivity without antagonizing the patient.

It is always prudent to determine what disorder the patient thinks or



fears he has, since his anxiety will not be relieved until he is convinced otherwise. Similarly, it may be helpful to determine whether the patient knows other persons with similar symptoms. This question often exposes fears of cancer, heart disease, ulcers, syphilis, high blood pressure, or insanity. If the conflict is superficial and the precipitating factors extrinsically obvious, the patient can sometimes be allowed to relate his troubles with resultant relief of symptoms. In such instances, either emphatic or evasive replies may be significant. When the conflict remains obscure, the patient may be told that his fatigue could result from tension or stress. He can then be asked whether he is aware of any particular strain or tension. After the examination is completed, the physician must decide whether the patient requires special psychiatric care. In general, the family physician can adequately treat patients whose conflicts are caused by extrinsic factors. Patients with psychotic symptoms or whose conflicts involve profound guilt or serious disturbance of basic emotional drives should be cared for by a psychiatrist.

Treatment

It is important that the patient understand that the physician does not consider the fatigue imaginary. For the physician to refute the existence of the complaint defeats treatment from the beginning. The patient may very properly believe the physician to be disinterested, disbelieving, or unobservant. It is relatively easy to explain to a patient how tension may cause fatigue. It can be explained that anxiety or tension can produce actual functional changes within the body and when stress persists indefinitely, it causes tension symptoms and, eventually, fatigue and exhaustion. It should be emphasized to the patient that each individual has a limit of tolerance for stress, and that when this limit is exceeded, there is nothing abnormal or weak in the body's reaction to excessive stress. Excellent results may be obtained if extrapsychic precipitating factors can be made evident to the patient. Obviously, if the stress situation cannot be recognized, the patient should not be advised to rest. Only patients

whose anxiety is marked by constant hyperactivity will be benefited by a curtailment of activities.

If the patient can be made to recognize the conflict situation himself, he is more likely to give credence to it than if it must be proposed to him by the physician. Even if the stress situation cannot be avoided or successfully resolved, insight often helps the patient to adjust to it.

Conclusion

When chronic fatigue is the most prominent feature of an illness, the origin is likely to be emotional. Emotional conflicts, whether obvious and conscious or hidden and unconscious produce generalized fatigue. Although fatigue may also accompany serious physical illness, in most cases by the time a physical condition has reached a debilitating stage, the underlying disorder if not apparent, will be relatively easy to diagnose. Fatigue is definitely influenced by interest, motivation, boredom, or monotony. Finally, it should be remembered that through the common association of fatigue with hard work, there is implicit social acceptability and approval in complaints of fatigue. When patients utilize fatigue as a defensive mechanism, insight therapy may make the patient become aware of his unconscious conflicts. Successful insight permits a more realistic appraisal of conflicting internal needs and desires and increases the chances of finding successful solutions. As emotional conflicts decrease, chronic fatigue in most cases will also diminish.

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• THE 1955 edition of the National Mental Health Committee's "fact sheet" reemphasizes with statistics the shocking acceleration in incidence of mental illness and the nationwide increase in its cost. WHAT ARE THE FACTS ABOUT MENTAL ILLNESS IN THE UNITED STATES presents a stark picture of the mental health of the nation. For example:

9,000,000 Americans have some form of mental disorder.

One of every two hospital beds in this country is occupied by a psychiatric patient.

There are approximately 2,400,000 persons that are subnormal, mentally.

In addition, the fact sheet points up the inadequate facilities and insufficient appropriations for research in mental health. Another seemingly inescapable fact, in that regard, is that one out of every 12 individuals in this country will spend part of his life in a mental hospital. About one-fourth of the resident patients in the average state mental institution have been hospitalized from one to five years; but, 60 per cent have been confined from five to 45 years, or longer, at a median annual cost per individual of $851.

The expense of care and treatment of mentally sick patients is steadily rising. This fact is conspicuously demonstrated by the Veterans Administration hospitals. In that particular group of institutions the cost has risen 500 per cent in the last ten years. Only a little more than two per cent of institutionalized psychiatric patients are in private hospitals, while 97.8 per cent are cared for in public ones.

The committee's report shows further distressing facts. For instance:

Each year about 250,000 new patients are admitted to mental hospitals.

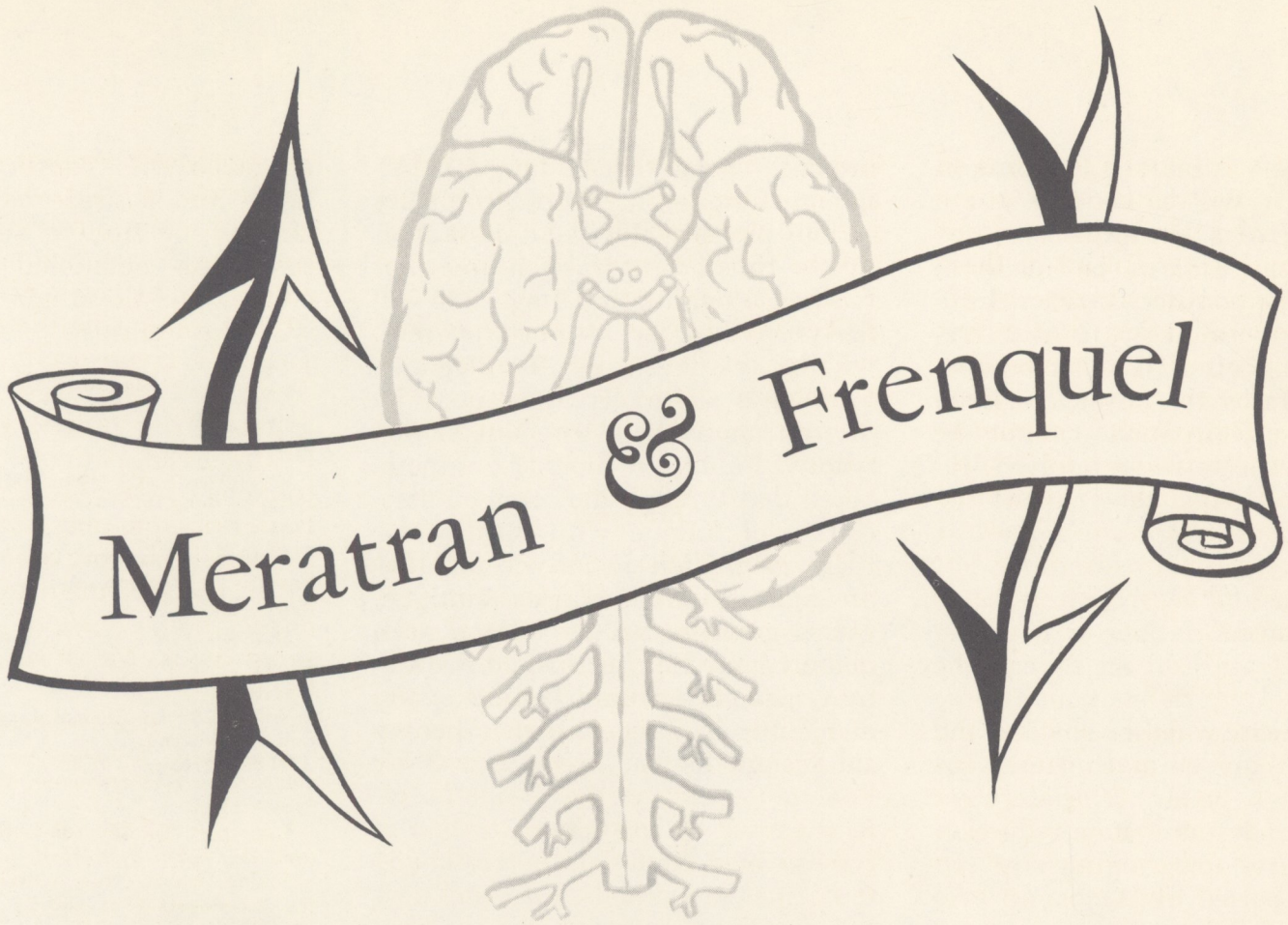
Additional thousands need hospitalization that is currently not available.

Forty per cent of the hospital beds accessible to mental patients are in unfit buildings, some of them in condemned ones.

The necessity for additional facilities for care and for more trained personnel is obvious. Actually, there are only about 600 mental hospitals in all of the United States. In state mental hospitals there is only one physician for every 228 patients, and only one nurse for every 104. Although mental health clinics are less expensive to operate than hospitals, and the development of such services is encouraging, they remain insufficient. Regrettably, a count of all full-time and part-time mental health clinics shows that for adequate services there is a shortage of more than 50 per cent. About 200,000 patients come to outpatient clinics. To provide minimal satisfactory services 840 additional clinics are needed.

A final vital need is for more funds and more facilities for research. In 1954 slightly more than $10,000,000 was spent on private psychiatric research. This figure includes Federal, state, and private expenditure; yet, in that same year, the cost of psychiatric care in the Veterans Administration hospitals alone was more than $200,000,000.

It has been established that research can save lives and money, and that prevention costs less than therapy. It has also been established that unless newer methods of effective treatment are found through research, one out of every twelve persons will some day require hospitalization for mental disorder. Nevertheless, while the total cost of mental illness to the United States in 1954 was $2,867,877,000, the investment on research was one half of one per cent of this amount. Two courses of immediate action, then, are necessary to increase the mental health of the nation. These are expansion of existing facilities for psychiatric care, and expenditure of more funds for psychiatric research.



● *This article is intended as an advance report on current research with Meratran and Frenquel. It is recommended that these drugs be used only in hospitals with complete psychiatric facilities.*

● EARLY IN 1954 Brown and Werner reported that purposeful hyperactivity could be induced in experimental animals by the administration of small doses of a new compound, alphapiperidyl benzhydrol. At its effective level this new compound was nontoxic; and since there was little effect on respiration, pulse rate, or blood pressure, the drug was used experimentally in a number of neuropsychiatric conditions. The results of these tests have proved that this substance, now available under the trade name of Meratran, is of value in the treatment of patients with different types of depression. Although it stimulates the central nervous system, Meratran is not a sympathomimetic drug, and does not have the undesirable side effects of amphetamine.

Because Meratran is a new type of drug and does not affect the autonomic nervous system, there has been considerable interest in its mode of action. Rinaldi and Himwich found that in rabbits it stimulated the reticular substance of the upper brain tegmentum, which then stimulated the cortex. The electrocorticogram showed fast frequencies and low amplitude characteristic of the alerting response. Heath reported that the new compound produced unusually high voltage spiking in the septal area of the monkey. Present evidence thus indicates that the primary site of action is in the area of the reticular formation of the upper brain stem. When the central nervous system is pathologically underactive, Meratran appears to restore it to a more normal level of activity and thus is clinically useful in many otherwise unrelated diseases. It will, however, aggravate excited states.

Indications

Narcoleptic patients were among the first to show a favorable response to Meratran therapy. Various amphetamine-type drugs have been only moderately successful in these patients, with concomitant undesirable side effects. In cases of narcolepsy, doses of 20 to 100 mg. of Meratran daily in three or four divided doses restored the patients to normalcy without affecting blood pressure or appetite. One patient received 100 mg. per day for over eighteen months without any apparent ill effects. When use of the drug is stopped, however, the symptoms soon recur.

Amphetamine derivatives which are effective in narcolepsy are often useful in the treatment of patients with certain depressive states. Consequently, Meratran was also tried in such cases. Fabing reported impressive results in 30 of his first 34 cases of reactive depression and in 17 of 27 cases of endogenous depression. In some instances the response was sudden and dramatic. For these patients doses of 2.5 mg. three times a day are usually effective; however, the comparatively high incidence of anxiety symptoms that are produced suggests that for the first week only one mg. three times daily should be employed. Response in various other types of neuropsychiatric illness has been variable. Patients with ambulatory and pseudoneurotic schizophrenia, presenile dementia, psychoses associated with arteriosclerosis, and Huntington's chorea do not respond to Meratran. Furthermore, the drug may cause exacerbation in seriously incapacitated patients with obsessive compulsion.

Antos has surveyed the effects of Meratran in patients with conditions characterized by fatigue, drowsiness, or a let-down feeling. A favorable reversal of these manifestations was observed when the symptoms were associated with therapeutic agents such as chlorpromazine, antihistamines, rauwolfia drugs, dihydrocodeinone, bromaleate, and barbiturates. Meratran also effectively alleviated depression associated with hepatitis, coccidioidomycosis, hypothyroidism, alcoholic hangover, and menopausal depression. It is useful

in control of occasional symptoms of depression or drowsiness that occur in epileptics who take anticonvulsant and hydantoin drugs. In all of these instances there is an absence of effects of overstimulation that result from use of other antidepressants. Preliminary results also suggest therapeutic effectiveness in stammering and in certain tics such as blepharospasm and spasmodic torticollis. Meratran affords promise of success in alleviating ordinary afternoon letdown and mental depression in many geriatric patients.

Dosage

Since Meratran does not affect the appetite, it may be given either before or after meals. Over-alertness at bedtime may necessitate reduction or omission of the evening dose. In one case reported by Antos, an evening dose of 2 mg. was given to a child to prevent enuresis. The child was able to maintain normal bladder control because the drug induced lighter than normal sleep. Fabing and coworkers have pointed out that because of the different degrees of severity of depressive reactions dosage must be adapted to the individual patient. For example, 1 to 2 mg. may suffice for afternoon let-down; 4 to 8 mg. may be required for reactive depression. Larger doses are seldom required except in the treatment of narcoleptic patients. In any case, overdosage may cause unpleasant tension.

Frenquel

Brown and Werner have found that the gamma isomer of Meratran prevents or diminishes the central stimulation caused in the mouse by Meratran, amphetamine, cocaine, and morphine. This new isomer, known as Frenquel, has been shown by Fabing to prevent the psychotic effects caused by the administration of lysergic acid diethylamine (LSD-25) to normal individuals. Frenquel does not, however, prevent the visceral effects produced by LSD-25. From preliminary observations, it appears that premedication with Frenquel blocks the model psychosis produced by mescaline sulfate. Although its action is not consistent, Frenquel has produced prompt and dramatic responses in patients with acute schizophrenia, alcoholic hallucinosis, senile and arteriosclerotic hallucinosis, and in cases of more chronic schizophrenic conditions. Frenquel is generally given orally in 10-20 mg. doses, and continued medication is apparently required except in the treatment of patients with delirium tremens. Like Meratran, Frenquel causes no apparent side effects. Thus Frenquel may prove to be as successful in the treatment of patients with dissociation, delusion, and hallucinations as is Meratran in depressed patients.

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Clinics and Statistics

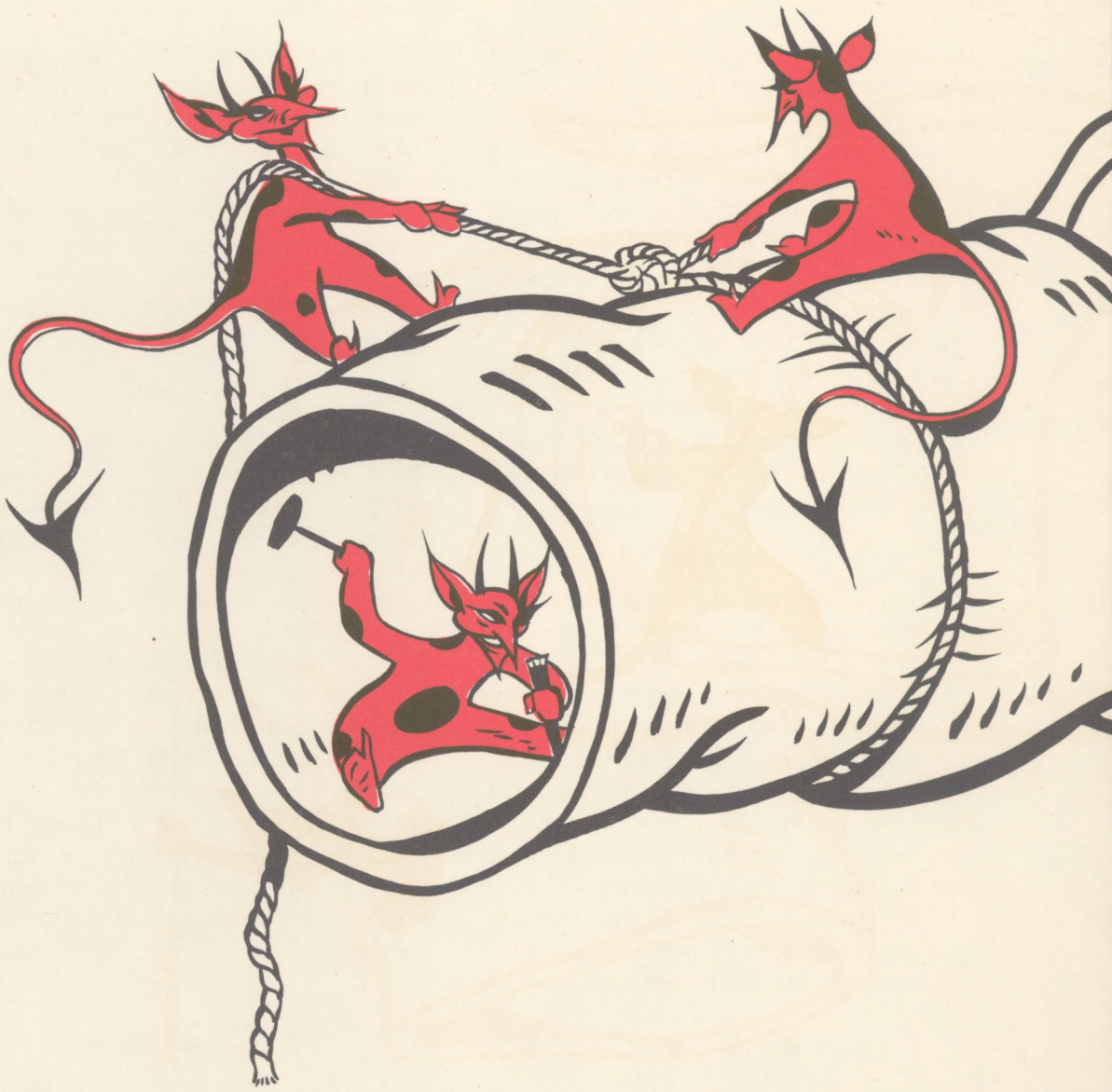
● ONE of the recurrent problems of epidemiology is the lack of uniformity in reports of case histories and treatment results. Hence, one of the objectives of the National Governors Conference on Mental Health in 1954 was future adoption of uniform statistical reporting procedures. Two months after that meeting, the First Conference on Mental Health Clinical Statistics, held at Bethesda, furthered this plan. A report form has been worked out at the National Institute for Mental Health with the help of state authorities, and it is now being tried for utility.

The functions of a clinic that are important and useful are difficult to measure. For statistical findings to be employed effectively they must be reported in such a way as to allow compilation and tabulation from different clinics. While it may seem an unimportant consideration, actually standardization of terms and forms is imperative. Accurate data are needed for training programs, for planning clinic facilities, for evaluation, and for research information. Without uniformity, correlation and assessment are impossible. To make such standardization possible, terminology and diagnostic classifications had to be clarified and a standard usage adopted.

First, it was essential to define a "psychiatric outpatient clinic" and to differentiate such a clinic from family service and counselling agencies or from clinics in which there is a psychiatrist on call or as a consultant. For a country-wide evaluation of mental hygiene services reports from all such centers will be needed, but the definition is limited to those clinics that offer outpatient services for ambulatory patients, and in which a psychiatrist with medical responsibility for all patients is regularly in attendance.

Report forms include the number and location of clinics, their auspices, staff, man-hours, and financial sources. The number, age, and sex of patients, as well as their disorders, services received, and therapeutic results are listed, along with additional clinic services, such as public mental health education. Some states' programs will give further data, such as referral sources, race, and reasons for termination. Annual statistical reports will then make comparisons possible, and data on a nationwide basis will be available for study and research.

Report forms are available from the Biometrics Branch, National Institute of Mental Health, National Institutes of Health, Public Health Service, Bethesda 14, Maryland.



ULCERATIV

● THE ETIOLOGY of ulcerative colitis remains obscure. Factors that have been investigated as possible causes include invasion by microorganisms, the influence of ingested allergens, avitaminosis, constitutional or genetic factors, and psychogenic disturbances. Emotional factors are said to be involved in approximately 60 per cent of all cases. Contrary to early reports, the incidence of ulcerative colitis is almost as high in children as in adults. It is, however, most often found among young adults and more often in men than in women. As in any disease in which a psychogenic factor is suspected, the physician should make a careful evaluation from a complete history.

Emotional factors

The following criteria suggested by Prugh may serve as a useful guide to the physician in the assessment of the significance of emotional elements in the etiology of this disease:

1. The existence of a basic psychological conflict regarding feelings toward a significant person in the patient's environment. This conflict may be predominantly unconscious, and the object of these ambivalent feelings is frequently the patient's mother or mother substitute. Other relatives and friends, however, should not be overlooked in identification of this figure.

2. The occurrence of an event of emotional significance to the patient which precedes by a day or two the onset of colic symptoms. Even a trivial event may act as a possible "trigger mechanism." Such an apparently inconsequential occurrence as criticism from a neighbor may be of importance if this neighbor is a close friend, and particularly if there is evidence that he is the object of an emotional conflict.

3. The presence of emotional benefit to the patient as a consequence of his physical disability. "Secondary gain" is a term often used to describe this phenomenon. Thus, a patient who is dependent on a rejecting, emotionally-distant person may be able to utilize his illness as a means of demanding love and support. In this way he obtains satisfaction of his emotional needs, but only if he remains ill.

4. Evidence of some basis for the unconscious choice of the colon as the "target" organ. In regard to this criterion, the physician will particularly want to explore data concerning the patient's toilet training. Such information as when training was instituted, the methods used, difficulties encountered, and the patient's feelings and attitudes may be valuable in understanding the current disease process.

Symbolic meanings

Freud, in presenting his theory of psychosexual development, contributed much to the knowledge of the symbolic meaning of defecation. He pointed out the possible significance of defecation as an act of gift-giving to parents as well as a demonstration of unexpressed aggression. An understanding of the patient with ulcerative colitis from this viewpoint may be helpful. Through a knowledge of the symbolic meaning of the disease, the physician may be in a better position to influence its course.

The case history

All of the data required to determine the applicability of the above criteria to a given case may not be readily obtainable from the patient. For example, the patient may not be conscious of the "secondary gains" which he derives from his illness. Astute observations of the patient and his interpersonal relationships by the physician may be of value in this instance. Another approach which may be worthwhile is that of interviewing persons close to the patient. The physician will have a chance to check on the information gathered directly from the patient, and additional information may be obtained. Finally, and most important, the physician will be able to avoid subjecting the patient to an

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undue amount of psychic stress because of the personal nature of the pertinent data.

Personality factors

The personality of patients with ulcerative colitis has been frequently cited in case reports. Among these characterizations, the descriptive terms include fearful, anxious, tense, immature, dependent, insecure, egocentric, neat, fussy, and depressed. From case studies, a composite picture of ulcerative colitis patients may be constructed. Despite an outwardly calm and relaxed appearance, these patients are frequently seething with anger and resentment which they are unable to express. Often they have an overwhelming need to be loved and to be reminded constantly that they are loved. At the same time, their conceptions of love are immature and romantically idealistic so that these patients are incapable of reacting to love in an adult manner. Psychological development has been such that these patients may never have developed enough self-adequacy or ego-strength or that they have regressed in this quality to a state of serious deficiency. Thus, because they lack sufficient ego-strength for successful interpersonal relationships, they must rely on more primitive methods in order to cope with emotional stresses. This inability to deal with emotional problems at a psychological level leads to extension of the defense system to a somatic level. Alexander has termed this process somatization.

This concept is valuable as a basis of differentiating psychosomatic disorders of the involuntary muscles of the viscera from those of the voluntary muscles. In the latter case, conversion hysteria is involved and serves as a *substitute* for the basic cause, the psychic stress. In the former case, the visceral changes *accompany* the psychic stress. Therefore, an increase of the psychic stress will often be concomitant with a worsening of the patient's somatic status.

An interesting observation that demonstrates this relationship is often seen in patients whose physical conditions improve markedly after hospitalization. Then, when they return to their home environments, the symptoms return. The reasons for this are not hard to find. These patients are returned to the original settings which precipitated the disease in the first place without sufficient reorientation of the psyche to enable them to meet emotional problems more adequately.

Psychophysiological mechanisms

Possible psychophysiological mechanisms in ulcerative colitis have been proposed by Prugh. He hypothesizes that hypothalamic centers may convey the emotional stimuli to the parasympathetic nervous system, which in turn, causes spasm of the colon. The resultant ischemia of the mucosa, complicated by loss of mucus, changes in enzymatic responses, and the appearance of subsequent microorganisms may result in permanent colonic injury. This psychic stress may be manifested as ulcerative colitis.

Comprehensive therapy

In the treatment of patients with ulcerative colitis consideration of the "whole person" is necessary. The ideal therapeutic arrangement would be the "team" approach with the general practitioner, internist, psychiatrist, clinical psychologist, and social worker contributing their respective skills. The team approach, of course, is not always possible. Hence, the physician must take into account and evaluate all factors bearing on the disease and not limit himself to the treatment of the focal physical problem.

Where psychological factors are clearly demonstrated in the etiology of ulcerative colitis, psychotherapy is valuable in the management of the patient. Hence, the time at which psychotherapy is to be instituted and the form it should take must be determined.

Psychotherapy

Psychotherapy should be instituted as soon as there is sufficient positive evidence of emotional factors in the etiology of the disease. In fact, psychotherapy technically begins at the time the physician, with the patient's aid, looks for evidence of emotional factors. In general initial psychotherapy should be supportive. At this stage an intensive, exploratory form of psychotherapy is contraindicated, particularly if the patient's signs and symptoms of disease are severe.

If there is definite correlation of onset of symptoms and emotional loss or alienation of a significant person in the patient's environment, a valuable form of supportive therapy is what Lindemann calls "psychological replacement therapy." This process involves three successive steps: the identification of the person who has become lost to the patient; an assessment of this person's role; and an attempt of the psychotherapist personally to replace the lost emotional object. Thus, the patient will be encouraged to return to his previous psychological status. In turn, this approach should help ameliorate the patient's physical condition.

"Psychological replacement therapy" or any other form of supportive therapy should not be regarded as a substitute for medical therapy. "Psychological replacement therapy" is simply an emergency measure that is helpful in initiating therapeutic management that will result in ultimate recovery. After this phase, the psychotherapeutic approach involves solution of more basic personality problems, particularly the patient's insufficient ego-strength.

This solution must be undertaken cautiously because of the danger of producing an exacerbation of the disease, or of precipitating a psychosis. The degree of mental illness is severe if the psychological defenses of the patient are so weakened as to result in the development of ulcerative colitis. To attack the already inadequate psychological defenses of the patient without sufficient bolstering of his ego is unrealistic and dangerous. Reports in the literature which describe alterations in the status of ulcerative colitis and psychosis attest to this fact.

If the patient is a child, and the emotional factors involve the parents, then part of the treatment should be directed to alleviating difficulties in their relationships. This can best be done by arranging for therapeutic interviews with the parents and for play therapy for the child. Perhaps milieu therapy may be necessary until the child's physical status improves. If the child is temporarily removed from the traumatic environment a remission may be obtained.

Suggested Reading

Alexander, F.: Psychosomatic Medicine, New York, W. W. Norton & Co., 1950, p. 122.

Grace, W. J.: Life Situations, Emotions and Chronic Ulcerative Colitis, A. Res. Publ. Nerv. & Ment. Dis., Proc. **29**:679, 1950.

Lindemann, E.: Modification in the Course of Ulcerative Colitis in Relationship to Changes in Life Situations and Reaction Patterns, A. Res. Publ. Nerv. & Ment. Dis., Proc. **29**:706, 1950.

Prugh, D. G.: Variations in Attitudes, Behavior, and Feeling-States as Exhibited in the Play of Children During Modifications in the Course of Ulcerative Colitis, A. Res. Publ. Nerv. & Ment. Dis., Proc. **29**:692, 1950.

Book Reviews

DENIAL OF ILLNESS. *By Weinstein, E. A., M. D. and Kahn, R. L., Ph. D. Pp. 166. Price $4.75. Springfield, Charles C Thomas, 1955.*

Studies of the symbolic and physiologic aspects of anosognosia have been made by the authors, a neuropsychiatrist and a research psychologist from The Mount Sinai Hospital, New York. They reviewed the literature on the subject of alterations in behavior after brain damage or disease and the findings are also presented in this monograph. Varied forms of denial and such manifestations as paraphasia, disorientation, and confabulations are described, as are the results of experimental pharmacological production of denial of illness. In the final chapter, the modes of adaptation to stress are discussed, and the clinical, neurological, pathological, and behavioral data on 104 cases with explicit or implicit denial of illness are summarized in tabular form. The volume has a generous bibliography.

EVALUATION IN MENTAL HEALTH. *Public Health Service Publication No. 413, Pp. 292. Price $2. Washington, D. C. Superintendent of Documents, 1955.*

This report from the Subcommittee on Evaluation of Mental Health Activities, National Advisory Mental Health Council, is a review of the evaluation studies in progress and of those in the literature. An annotated bibliography of such projects is thus made available to investigators and professional workers, with an analysis of the material included. The reference list contains 431 items, and the supplementary entries in the appendix bring the total to 984. The literature concerning particular instruments of measurement was not included, nor were overlapping studies, nor studies of drugs and surgical methods.

The volume has a complete author index. For convenience, the references are organized in seven categories: community organization, administration, professional personnel, education and information, preventive effects of programs, factors that influence individual mental health, and diagnostic, prognostic, and treatment procedures. It is hoped that this report will facilitate research progress and increase interest in evaluative programs.

THE DOCTOR'S PARTNERS

● All Texas doctors, even those who work alone, serve as members of an important team and call upon the assistance of a number of partners.

● These partners consist of the psychiatric facilities available throughout the state—the private psychiatrists in almost every community of size and the many other resources in the treatment of psychiatric problems and, still more important, in the prevention of those problems.

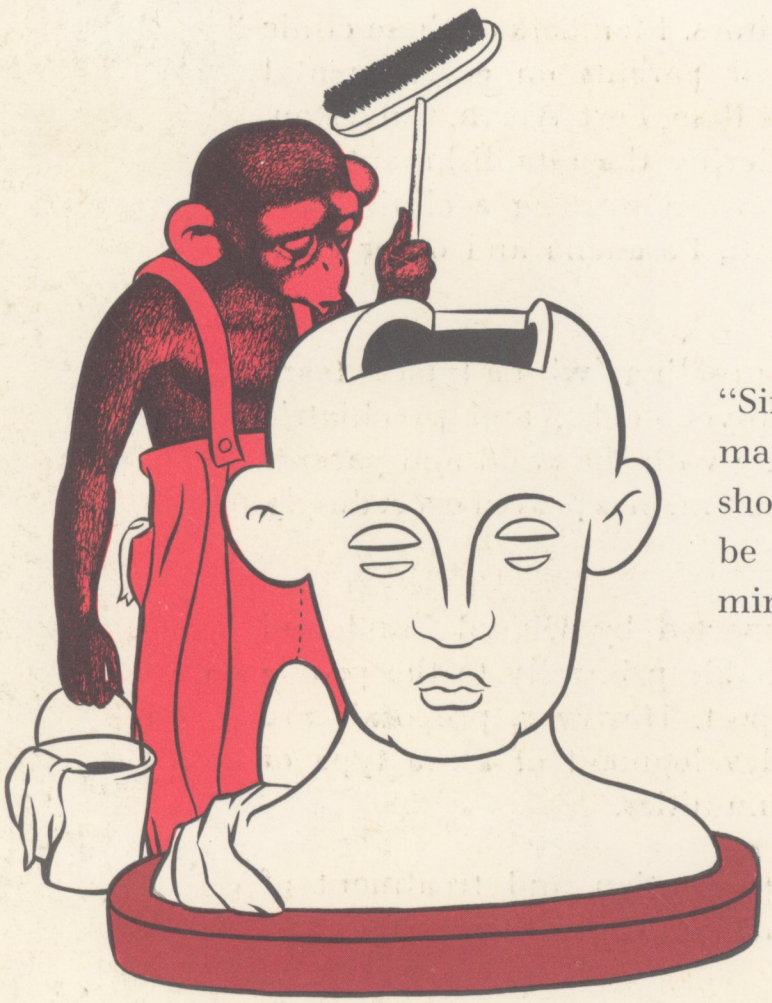
● *The Psychiatric Bulletin,* which has been made a part of the program of the Hogg Foundation for the year, will bring psychiatric information in practical form to the more than 7,000 physicians of the state. In this way, it will serve as still another partner of the general practitioner. The State Department of Health has been interested in this partnership for several years.

● One important partner in the preventive field lies in the child guidance or community guidance clinics. Members of these clinic teams are seeing children and their parents on early mental health problems in Austin, Dallas, El Paso, Fort Worth, Galveston, and Houston. San Antonio is considering the establishment of a clinic within the year, and steps toward starting a clinic have been made in Abilene, Corpus Christi, Pasadena and other communities in the state.

● The results of this type of clinic counseling (with a typical team consisting of psychiatrist, clinical psychologist, and psychiatric social worker studying and conferring with the child and parents in understanding the cause of the problem) has proved exceedingly beneficial.

● Since these clinics are often supported by United Fund and other local resources, they are available primarily to the people living within the area of this support. However, proposals are now under consideration for the development of some type of service for rural areas and small communities.

● Other partners in the field of prevention and treatment of psychiatric problems will be mentioned in subsequent issues.



"Since there is nothing in the world more excellent than man, nor in man than his mind, particular attention should be given to the welfare of the mind; and it should be considered a highest service if we either restore the minds of others to sanity or keep them sane and rational."

Luis Vives, De Subventione Pauperum, *quoted by Foster Watson, Luis Vives el gran Valenciano (1492-1549) Oxford University Press, 1922.*